STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

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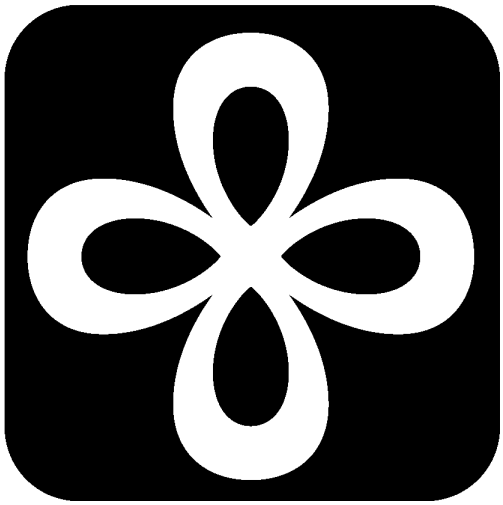

Provider Manual

Hospice Services

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APPENDIX

I. HOSPICE SERVICE

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill people. A hospice provides palliative and supportive services to meet the physical, psychosocial, social, and spiritual needs of a terminally ill person and the person's family or others caring for the person, regardless of where the person resides. Hospice services are those services to control pain and provide support to people to continue life with as little disruption as possible.

Payment for hospice services will be approved for Medicaid recipients who are certified terminally ill and who elect hospice care rather than active treatment for the illness. A recipient is considered terminally ill if the recipient's medical prognosis states the life expectancy will be six months or less if the terminal illness runs its normal course. Recipients eligible for hospice under Medicare must use hospice services as provided by Medicare rather than Medicaid.

II. STANDARDS FOR HOSPICE PROVIDERS

Only hospice providers certified to participate in the Medicare hospice program are eligible to participate as Medicaid hospice providers.

III. COVERED SERVICES

There are eight services provided by a hospice agency. Nursing care, medical social services, and counseling are core hospice services. Core services must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.

A. Core Hospice Services

1. Nursing care provided by or under the supervision of a registered nurse.

2. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

3. Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at home. Counseling including bereavement, dietary, and spiritual counseling, may be provided both for the purpose of training the recipient's family or other care-giver to provide care, and for the purpose of helping the recipient and those caring for the recipient to adjust to the recipient's approaching death.

B. Supplemental Services

1. Short-term inpatient care provided in a participating hospital. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the recipient's family or other persons caring for the recipient at home. Respite care is the only type of inpatient care that may be provided in a nursing facility.

2. Medical appliances and supplies, including drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to recipient's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness. Equipment is provided by the hospice for use in the recipient's home while the recipient is under hospice care. Medical supplies include those that are part of the written plan of care.

3. Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the home health aide to carry out the plan of care.

4. Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the recipient to maintain activities of daily living and basic functional skills unless this provision has been waived under the Medicare program for a specific provider.

5. Physicians' services performed by a physician except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

6. Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

IV. RELATED SERVICES

The following are services not covered in the hospice reimbursement rate but which are reimbursable through the Medicaid program:

- Services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Covered services unrelated to the terminal illness shall be billed separately by the respective provider.
- Direct physician care.
- Service costs not covered by the health maintenance organization (HMO) when the recipient is enrolled in an HMO and elects hospice.
- AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

V. ELECTION PROCEDURES

A. Initial Election

Recipients eligible for both Medicare and Medicaid hospice must accept the Medicare hospice benefit. The recipient or recipient's representative shall complete form 470-2618, *Election of Medicaid Hospice Benefit,* or the hospice agency may use another election form. When another form is used it must include the following information:

- Identification of the hospice provider.
- Acknowledgment that the recipient has been given a full understanding of hospice care.
- Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.

- Acknowledgment that recipients are not responsible for copayment or other deductibles.
- The recipient's Medicaid number.
- The effective date of election.
- The recipient's signature.

The election periods for Medicaid hospice consist of up to two periods of 90 days each, and an unlimited number of subsequent 60-day periods as elected.

The election to receive hospice care will be considered to continue until one of the following occurs:

- The recipient dies.
- The recipient or the recipient's representative revokes the election.
- The recipient's situation changes so that the recipient no longer qualifies for the hospice benefit.
- The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

B. Waiver of Medicaid Payments

A recipient must waive all rights to Medicaid payment for the terminal illness for the duration of the election of hospice care.

C. Change of Hospice

The recipient or the recipient's representative may change the designation of the particular hospice from which the recipient receives hospice care one time only.

The change from one hospice provider to another is not considered a revocation of the election. A change of ownership of a hospice is not considered a change in the recipient's designation of a hospice. It requires no action on the recipient's part.

The hospice agency from which the recipient has received care shall assist the recipient with completion of form 470-2618, *Election of Hospice Benefit.* The effective date is the last date the first hospice provided service.

The new hospice agency shall assist the recipient with completion of form 470-2618, *Election of Hospice Benefit.* The effective date is the first day the new agency provided service.

D. Revocation of Election

A recipient or a recipient's representative may revoke the hospice benefit at any time. The hospice agency shall assist in completion of form 470-2619, *Revocation of Hospice Benefit.* A recipient may not designate an effective date earlier than the date that the revocation is made.

Upon revoking the election of Medicaid coverage of hospice care, the recipient resumes Medicaid coverage of the benefits waived. A recipient may at any time elect to receive hospice coverage.

VI. REQUIREMENTS FOR COVERAGE

A. Physician's Certification

The hospice must obtain a physician's certification that the recipient is terminally ill. The certification must be signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the recipient's attending physician (if the recipient has an attending physician). The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the recipient at the time the recipient elects to receive hospice care, as having the most significant role in the determination and delivery of the recipient's medical care.

The hospice must follow established guidelines for physician certification. The hospice must obtain certification that a patient is terminally ill in accordance with the following procedures:

- The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the patient's attending physician (if the patient has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the patient's medical prognosis is that the patient's life expectancy is six months or less, if the terminal illness runs its normal course.

- When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the patient's attending physician (if the patient has an attending physician). The certification must include the statement that the patient's medical prognosis is that the patient's life expectancy is six months or less, if the terminal illness runs its normal course.

- Hospice care benefit periods consist of up to two periods of 90 days each, and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or physician must recertify at the beginning of each period that the individual is terminally ill.

B. Hospice Requirements

To be reimbursed by Medicaid, the hospice must meet the following conditions:

- The hospice must be certified to participate in the Medicare hospice program.
- The hospice must maintain certification by a physician that the recipient is terminally ill.
- Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.
- The recipient must have completed form 470-2168, *Election of Hospice Benefit*.
- A plan of care must be established before services are provided. Services provided shall be consistent with the plan of care.

  In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the recipient's needs must meet or call at least one other group member (nurse, physician, medical service worker or counselor) before writing the initial plan care. At least one of the persons involved in developing the initial plan must be a nurse or physician. If the day of assessment is to be a covered day of hospice care, this plan must be established on the same day as the assessment. The other two members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment.

VII. BASIS OF PAYMENT FOR SERVICES

A. Levels of Reimbursement

The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the recipient for that day. The rates are prospective rates. There will be no retroactive adjustment other than the application of the cap on overall payments and limits on payment for inpatient care. Payments to a hospice for inpatient care are subject to the limit imposed by Medicare. No cost sharing may be imposed with respect to hospice services rendered to Medicaid recipients.

Medicaid reimbursement is based on the type and intensity of services furnished to the recipient for that day. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. Each of the four levels of care has a predetermined reimbursement rate. Payment is based on the geographic location at which the service is furnished (as opposed to the location of the hospice). The metropolitan statistical area (MSA)/rural state code must be included on the claim for these revenue codes.* The levels of care are:

Level	Revenue Code
Routine home care*	651
Continuous home care*	652
Inpatient respite care	655
General inpatient care	656

A description of each level of care follows:

1. Routine Home Care

   The hospice will be paid the routine home care rate for each day the recipient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

2. Continuous Home Care

   Continuous home care is covered when it is provided to maintain a recipient at home during a period of medical crisis. A period of crisis is a period of time when a recipient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse. A nurse must be providing care for more than half of the care given in a hour period. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

   The amount of payment is determined based on the number of hours of continuous care furnished to the recipient on that day. A minimum of eight hours must be provided during a 24-hour period which begins and ends at midnight before the continuous home care rate can be billed. This care need not be provided all at once, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care.

3. Inpatient Respite Care

Respite inpatient care is short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient at home. Respite care is not paid when the hospice recipient is residing in a nursing facility.

The hospice is paid at the inpatient rate for maximum of five days at a time when the recipient is in an approved inpatient facility.

Payment is made for date of admission but not for date of discharge. The discharge day for inpatient respite care is billed as routine home care or continuing home care, unless the patient is discharged as deceased. When the patient is discharged as deceased, the inpatient respite care rate is billed.

4. General Inpatient Care

General inpatient care is provided in periods of acute medical crisis when the recipient is hospitalized for pain control or acute or chronic symptom management. None of the other fixed payment rates (e.g., routine home care) are applicable for a day on which the patient receives hospice inpatient care, except for the day of discharge from an inpatient unit.

The discharge day for general inpatient care is billed as routine home care or continuous home care, unless the patient is discharged as deceased. When the patient is discharged as deceased, the general inpatient rate is billed.

B. Limit on Payments for Inpatient Care

Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limit. This limit is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home-care rate will not be counted as inpatient days. The limit is calculated as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

2. If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.

3. If the total number of days of inpatient care exceeds the maximum allowable number, the limit is determined by:

    a. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

    b. Multiplying excess inpatient care days by the routine home care rate.

c. Adding together the amounts calculated in a. and b.

d. Comparing the amount in c. with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

C. Hospice in a Nursing Facility

1. For recipients residing in a nursing facility, the requirement that the care must be provided under the immediate direction of either the facility or the reception's personal physician does not apply when all of the following conditions are met:

   a. The recipient is terminally ill.

   b. The recipient has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

   c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the recipient's hospice care and the facility agrees to provide room and board to the resident. A copy of the written agreement shall be filed in recipient's records.

2. Medicaid <u>will not pay</u> for inpatient respite care for a recipient who resides in a nursing facility. Respite is designed to provide temporary relief for family members.

   Medicaid <u>will pay</u> for routine home care and continuous home care for a recipient who resides in a nursing facility.

Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the recipient's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

3. Before providing hospice service to a Medicaid recipient in a nursing facility, the hospice agency shall contact the recipient's local Department income maintenance worker to report election of hospice, so the worker can terminate the nursing facility payment and the agency can verify the amount of client participation to be collected per month.

   Client participation is collected when the recipient is in a nursing facility. The hospice is responsible for collection of the client participation, unless the hospice and nursing facility jointly determine the nursing facility is to collect the client participation. The amount collected is paid to the nursing facility. For example, the board and room rate cost per month is $700.00, and the client participation is $300.00 per month. The hospice collects $300.00 from the recipient, bills Medicaid $400.00, and pays the nursing facility $700.00.

   An adjustment is made to the hospice reimbursement when the recipient resides in a nursing facility. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. The cost of room and board can be obtained from the facility.

   For hospice recipients entering a nursing facility, the adjustment will be effective the date of entry. For persons in a nursing care facility before the hospice election, the adjustment rate shall be effective the date of election. The room and board costs paid by hospice are not subject to the cap on overall reimbursement.

4. The nursing facility handbook contains information which instructs facilities how to report revenues paid by the hospice agency. The hospice agency will want to be sure the nursing facility is aware the information is to be reported.

D. Payment for Physician Services

1. Group Activities

The basic payment rates for hospice reimbursement reflects the costs of covered services related to the treatment of the recipient's terminal illness. This includes the administrative and general supervisory activities performed by the medical director, physician, if employed by the hospice, or consulting physician. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs of these services are included in the reimbursement rates for routine home care, continuous home care, inpatient respite care, and general inpatient care.

2. Attending Physician Services

When the designated attending physician is not a hospice employee or volunteer, the reimbursement of an independent physician is made in accordance with usual Medicaid reimbursement and is not counted to determine if the hospice cap amount has been exceeded. The physician bills Medicaid directly. The only services billed by the attending physician shall be the physician's personal professional services. Costs for services such as lab or X-rays shall not be included on the attending physician's bill.

3. Direct Care Services

Direct physician patient care provided by a hospice employee or any physician other than the attending physician is billed to Medicaid by the hospice agency. Reimbursement will be in accordance with the Medicaid payment schedule. Payment for direct patient care by the physician is counted in determining the hospice cap amounts. When billing on the UB-92 (HCFA-1450) for physician's services, use the CPT-4 code.

4. Voluntary Direct Care

Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. A physician may volunteer to provide specific services and seek reimbursement for some other services. The hospice must have a liability to reimburse the physician for services provided before reimbursement is claimed.

In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid patients on the same basis as other patients in the hospice. For instance, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid patients.

Example: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Mrs. Smith, a Medicaid recipient, enters this hospice and designates Dr. Jones as her attending physician. Dr. Jones, who does not furnish direct patient care services on a volunteer basis, renders a direct patient care service to Mrs. Smith. Dr. Jones seeks reimbursement from the hospice for this service. The hospice is paid by Medicaid at the usual payment rate for the specific services Dr. Jones rendered to Mrs. Smith. The hospice then reimburses Dr. Jones for this service. Dr. Jones, by virtue of his volunteer activities, is deemed to be an employee of the hospice. Accordingly, his volunteer services are included in determining whether the optional Medicaid cap amount has been exceeded.

E. Hospice Cap

Overall aggregate payment made to a hospice during a year are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year.

The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the Department by the hospice.

I. FORM 470-2618, ELECTION OF MEDICAID HOSPICE BENEFIT

A. Facsimile of Form

(See page F-3.)

B. Instructions for Completing Form

The hospice is responsible for completion of form 470-2618 or a form containing the data items described in Chapter E for all Medicaid-eligible recipients. Complete Sections 1 and 5 and Section 3, if applicable.

For Medicare-eligible clients who are also Medicaid-eligible, the hospice must provide both Medicare and Medicaid numbers on claims filed. Complete Sections 1, 2, and 5, and Section 3, if applicable.

When the recipient changes hospice providers, complete Sections 1, 4, and 5, and Section 3, if applicable.

SECTION 1 – MEDICAID INFORMATION

Recipient Name
Enter the Medicaid recipient's name as it appears on the *Medical Assistance Eligibility Card*.

Medicaid Number
Enter the recipient's state identification number as it appears on the *Medical Assistance Eligibility Card*. This number consists of seven numeric characters and an ending alphabetic character; for example, 1234567A.

Beginning Date of Care
Enter the date hospice service was first provided.

Hospice Name
Enter the provider agency's name.

Medicaid Provider Number
Enter the hospice's seven-digit Iowa Medicaid identification number.

Attending Physician Name and Phone
Enter data if applicable.

SECTION 2 – MEDICARE INFORMATION

Medicare Patient Name
Enter the recipient's name as it appears on the Medicare card.

Medicare Claim Number
Enter the Medicare claim number as it appears on the Medicare card.

Begin Date
Enter the date Medicare hospice coverage began.

End Date
Enter the date Medicare hospice benefit was terminated, if applicable.

SECTION 3 – NURSING FACILITY INFORMATION

Facility Name
Enter the name of the care facility where the recipient resides.

Medicaid Provider Number
Enter the facility's seven-digit Iowa Medicaid provider number. ICF level always begins with 080 and SNF level always begins with 065.

Facility Address
Enter the complete mailing address of the facility.

Iowa Department of Human Services

ELECTION OF MEDICAID HOSPICE BENEFIT

I understand that my disease is incurable. I consent to the management of the symptoms of my disease by the hospice. I understand the care services provided by the hospice are nursing care, physician services, medical social services and counseling. If needed I may also receive short-term inpatient care, medical appliances and supplies, home health service and physical therapy, occupational therapy and speech or language pathology service. I have been given a full understanding of hospice services.

I understand I waive my right to regular Medicaid benefits, except for payment to my regular physician and treatment for medical conditions unrelated to my terminal illness.

I understand the election of hospice care continues as long as I remain in hospice and do not revoke the election. If I revoke my choice of hospice benefits, I can resume regular Medicaid benefits if I am still eligible.

I understand Medicaid recipients are not responsible for co-pay or other deductibles.

I understand that if I reside in a nursing home and receive hospice, I must pay the amount of client participation determined by the Department of Human Services.

I understand that the hospice benefit is a home care program. If my family and I choose care not available from the hospice agency, I understand that the hospice and the Medicaid program are not financially responsible.

I understand that I may change hospice providers once during my certification by completing a new form.

Section 1. Medicaid Information

Recipient Name	Medicaid No.	Begin Date of Care
Hospice Name		Medicaid Provider No.
Attending Physician Name		Phone No.

Section 2. Medicare Information

Medicare Patient Name	Medicare Claim No.	Begin Date	End Date

Section 3. Nursing Facility Information

Facility Name	Medicaid Provider No.
Facility Address	

Section 4. Hospice Change

Present Hospice	Medicaid Provider No.	Effective Date of Change
New Hospice	Medicaid Provider No.	Effective Date of Change

Section 5. Signatures

Recipient's Signature or Mark	Date Signed	Witness' Signature	Date Signed

470-2618 (1/90)

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SECTION 4 – HOSPICE CHANGE

Present Hospice
Enter the name of the hospice presently providing service.

Medicaid Provider Number
Enter the seven-digit Medicaid number of the hospice presently providing service.

Effective Date of Change
Enter the last date the present hospice provided service.

New Hospice
Enter the name and the Medicaid provider number of the hospice taking over service. Enter the date this hospice begins service.

SECTION 5 – SIGNATURES

Recipient's Signature or Mark and Date
Enter the recipient's name as it appears on the *Medical Assistance Eligibility Card*. The recipient's representative may sign the recipient's name, if necessary. Enter the date this form is signed.

Witness' Signature and Date
Enter the name of the person who witnessed the recipient's signature. Enter the date this form is signed.

Distribution: Retain the original in the recipient's file, and give one copy to the recipient or the recipient's representative. When the recipient resides in a nursing home, send a copy to the recipient's income maintenance worker at the county Department of Human Services office.

II. FORM 470-2619, REVOCATION OF MEDICAID HOSPICE BENEFIT

A. Facsimile of Form

(See page F-7.)

B. Instructions for Completing Form

The hospice is responsible for completion of form 470-2619. This form must be used to revoke hospice.

Recipient Name and Medicaid Number
Enter the Medicaid recipient's name as it appears on the *Medical Assistance Eligibility Card*. Enter the recipient's state identification number as it appears on the same card. This number consists of seven numeric characters followed by an alphabetic character; for example, 1234567A.

Agency Name and Provider Number
Enter the hospice's name. Enter the hospice's Iowa Medicaid provider number.

Date
Enter the first date following the day that the last hospice service was provided.

Recipient's Signature
Enter the signature of the recipient or the recipient's representative.

Witness' Signature
Enter the signature of the person who witnessed the recipient's signature.

Date
Enter the date the form is signed.

Distribution: Retain the original in the recipient's file and give one copy to the recipient or the recipient's representative. When the recipient resides in a nursing home, send one copy to the recipient's income maintenance worker at the county Department of Human Services office.

Iowa Department of Human Services

REVOCATION OF MEDICAID HOSPICE BENEFIT

I, _____ (Recipient's name) , _____ (Medicaid number) ,

choose to revoke the hospice benefit allowed to me by Medicaid and rendered by

_____ (Agency name) , _____ (Agency provider number) , as of

_____ , 19 _____ .

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

_____	_____
Recipient's signature	Witness' signature
_____	_____
Date	Date

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III. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the UB-92 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	PROVIDER'S NAME, ADDRESS & TELEPHONE NUMBER	**OPTIONAL** – Enter the complete name, address, and phone number of the billing facility or service supplier.
2.	PAYER CONTROL NUMBER	**LEAVE BLANK.**
3.	PATIENT CONTROL NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
4.	TYPE OF BILL	**REQUIRED*** – Enter a three-digit number consisting of one digit from each of the following categories in this sequence: First digit Type of facility Second digit Bill classification Third digit Frequency

		Type of Facility 1 Hospital or psychiatric medical institution for children (PMIC) 2 Skilled nursing facility 3 Home health agency 7 Rehabilitation agency 8 Hospice Bill Classification 1 Inpatient hospital, inpatient SNF or hospice (nonhospital based) 2 Hospice (hospital based) 3 Outpatient hospital, outpatient SNF or hospice (hospital based) 4 Hospital referenced laboratory services, home health agency, rehabilitation agency Frequency 1 Admit through discharge claim 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim
5.	FEDERAL TAX NUMBER	**OPTIONAL** – No entry required.
6.	STATEMENT COVERS PERIOD	**REQUIRED** – Enter the month, day, and year under both the From and To categories for the period.
7.	COVERED DAYS	**REQUIRED FOR INPATIENT*** – Inpatient, PMIC, and SNF – Enter the number of covered days. Do not use the day of discharge in your calculations. Rehabilitation Agency – Enter the number of days the patient was seen in this billing period. The number of days is used to determine copayment liability. Hospice Services and Home Health Agencies – Leave blank.

8.	NONCOVERED DAYS	**REQUIRED FOR INPATIENT, WHERE APPLICABLE*** – Inpatient, PMIC, and SNF – Enter the number of non-covered days, if applicable. Do not use the day of discharge in your calculations. Hospice Services, Rehabilitation, and Home Health Agencies – Leave blank.
9.	COINSURANCE DAYS	**OPTIONAL** – No entry required.
10.	LIFETIME RESERVE DAYS	**OPTIONAL** – No entry required.
11.	UNLABELED FIELD	**OPTIONAL** – No entry required.
12.	PATIENT NAME	**REQUIRED** – Enter the last name, first name, and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
13.	PATIENT ADDRESS	**OPTIONAL*** – Enter the full address of the recipient.
14.	PATIENT BIRTHDATE	**OPTIONAL** – Enter the recipient's birthdate as month, day, and year. Completing this field may expedite processing of your claim.
15.	PATIENT SEX	**REQUIRED** – Enter the patient's sex.
16.	PATIENT MARITAL STATUS	**OPTIONAL** – No entry required.
17.	ADMISSION DATE	**REQUIRED*** – Inpatient, PMIC, and SNF – Enter the date of admission for inpatient services. Outpatient – Enter the dates of service. Home Health Agency and Hospice – Enter the date of admission for care. Rehabilitation Agency – No entry required.

18.	ADMISSION HOUR	**REQUIRED FOR INPATIENT/PMIC/SNF** – The following chart consists of possible admission times and a corresponding code. Enter the code that corresponds to the hour patient was admitted for inpatient care. Code – Time - AM: 00 – 12:00 - 12:59 Midnight; 01 – 1:00 - 1:59; 02 – 2:00 - 2:59; 03 – 3:00 - 3:59; 04 – 4:00 - 4:59; 05 – 5:00 - 5:59; 06 – 6:00 - 6:59; 07 – 7:00 - 7:59; 08 – 8:00 - 8:59; 09 – 9:00 - 9:59; 10 – 10:00 - 10:59; 11 – 11:00 - 11:59 Code – Time - PM: 12 – 12:00 - 12:59 Noon; 13 – 1:00 - 1:59; 14 – 2:00 - 2:59; 15 – 3:00 - 3:59; 16 – 4:00 - 4:59; 17 – 5:00 - 5:59; 18 – 6:00 - 6:59; 19 – 7:00 - 7:59; 20 – 8:00 - 8:59; 21 – 9:00 - 9:59; 22 – 10:00 - 10:59; 23 – 11:00 - 11:59; 99 – Hour unknown
19.	TYPE OF ADMISSION	**REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code corresponding to the priority level of this inpatient admission. 1 Emergency 2 Urgent 3 Elective 4 Newborn 9 Information unavailable
20.	SOURCE OF ADMISSION	**REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code that corresponds to the source of this admission. 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information unavailable

21.	DISCHARGE HOUR	**REQUIRED FOR INPATIENT/PMIC/SNF** – The following chart consists of possible discharge times and a corresponding code. Enter the code that corresponds to the hour patient was discharged from inpatient care. See **Field 18, Admission Hour**, for instructions for accepted discharge hour codes.
22.	PATIENT STATUS	**REQUIRED FOR INPATIENT/PMIC/SNF** – Enter the code that corresponds to the status of the patient at the end of service. 01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to other short-term general hospital for inpatient care 03 Discharged/transferred to a skilled nursing facility (SNF) 04 Discharged/transferred to an intermediate care facility (ICF) 05 Discharged/transferred to another type of institution for inpatient care or outpatient services 06 Discharged/transferred to home with care of organized home health services 07 Left care against medical advice or otherwise discontinued own care 08 Discharged/transferred to home with care of home IV provider 10 Discharged/transferred to mental health care 11 Discharged/transferred to Medicaid certified rehabilitation unit 12 Discharged/transferred to Medicaid certified substance abuse unit 13 Discharged/transferred to Medicaid certified psychiatric unit 20 Expired 30 Remains a patient or is expected to return for outpatient services (valid only for nonDRG claims)

23.	MEDICAL/ HEALTH RECORD NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
24. – 30.	CONDITION CODES	**CONDITIONAL*** – Enter corresponding codes to indicate whether or not treatment billed on this claim is related to any condition listed below. Up to seven codes may be used to describe the conditions surrounding a patient's treatment. <u>General</u> 01 Military service related 02 Condition is employment related 03 Patient covered by an insurance not reflected here 04 HMO enrollee 05 Lien has been filed <u>Inpatient Only</u> 80 Neonatal level II or III unit 81 Physical rehabilitation unit 82 Substance abuse unit 83 Psychiatric unit X3 IFMC approved lower level of care, ICF X4 IFMC approved lower level of care, SNF 91 Respite care <u>Outpatient Only</u> 84 Cardiac rehabilitation program 85 Eating disorder program 86 Mental health program 87 Substance abuse program 88 Pain management program 89 Diabetic education program 90 Pulmonary rehabilitation program 98 Pregnancy indicator – outpatient or rehabilitation agency

		Special Program Indicator A1 EPSDT A2 Physically handicapped children's program A3 Special federal funding A4 Family planning A5 Disability A6 Vaccine/Medicare 100% payment A7 Induced abortion – danger to life A8 Induced abortion – victim rape/incest A9 Second opinion surgery Home Health Agency (Medicare not applicable) XA Condition stable XB Not homebound XC Maintenance care XD No skilled service
31.	UNLABELED FIELD	**OPTIONAL** – No entry required.
32. – 35. A. & B.	OCCURRENCE CODES AND DATES	**REQUIRED IF APPLICABLE*** – If any of the occurrences listed below is applicable to this claim, enter the corresponding code and the month, day, and year of that occurrence. Accident Related 01 Auto accident 02 No fault insurance involved, including auto accident/other 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim

		Insurance Related 17 Date outpatient occupational plan established or reviewed 24 Date insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan was established or last reviewed A3 Medicare benefits exhausted Other 11 Date of onset
36. A. & B.	OCCURRENCE SPAN CODES AND DATES	**OPTIONAL** – No entry required.
37. A. – C.	TRANSACTION CONTROL NUMBER	**LEAVE BLANK.**
38.	RESPONSIBLE PARTY NAME AND ADDRESS	**OPTIONAL** – No entry required.
39. – 41. a. – d.	VALID CODES AND AMOUNTS	**REQUIRED** – For hospices with revenue codes 651 or 652. Show value code 61 in the code area and the 4-5 position and MSA in the amount field. The MSA is determined by the geographical location at which the service is furnished. 1360 Linn 1960 Scott 2120 Dallas, Polk, Warren 3500 Johnson 5920 Pottawattamie 7720 Woodbury 8920 Black Hawk 9916 Bremer 9916 Rest of Iowa
42.	REVENUE CODE	**REQUIRED** – Enter the appropriate corresponding revenue code for each item or service billed. Replace the "X" with a subcategory code, where appropriate, to clarify the code. Please note that all listed revenue codes are not payable by Medicaid. If you have questions concerning payment for a specific item/service, please call Provider Relations at 1-800-338-7909 or 515-327-5120 (in Des Moines).

11X Room & Board – Private (medical or general)
Routine service charges for single bed rooms.

Subcategories

0 General classifications
1 Medical/surgical/GYN
2 OB
3 Pediatric
4 Psychiatric
6 Detoxification
7 Oncology
8 Rehabilitation
9 Other

12X Room & Board – Semi-Private Two Bed (medical or general)
Routine service charges incurred for accommodations with two beds.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

13X Room & Board – Semi-Private Three and Four Beds (medical or general)
Routine service charges incurred for accommodations with three and four beds.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

14X Private (deluxe)
Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

15X Room & Board – Ward (medical or general)
Routine service charge for accommodations with five or more beds.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

16X Other Room & Board
Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategories

0 General classifications
4 Sterile environment
7 Self care
9 Other

17X Nursery
Charges for nursing care to newborn and premature infants in nurseries.

Subcategories

0 General classification
1 Newborn
2 Premature
5 Neonatal ICU
9 Other

18X Leave of Absence
Charges for holding a room or bed for a patient while the patient is temporarily away from the provider.

Subcategory

5 Nursing home (for hospitalization)

20X Intensive Care
Routine service for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Subcategories

0 General classification
1 Surgical
2 Medical
3 Pediatric
4 Psychiatric
6 Post ICU
7 Burn care
8 Trauma
9 Other intensive care

21X Coronary Care
Routine service charge for medical care provided to patients with coronary illnesses requiring a more intensive level of care than is rendered in the general medical care unit.

Subcategories

0 General classification
1 Myocardial infarction
2 Pulmonary care
3 Heart transplant
4 Post CCU
9 Other coronary care

22X Special Charges
Charges incurred during an inpatient stay or on a daily basis for certain services.

Subcategories

0 General classification
1 Admission charge
2 Technical support charge
3 U.R. service charge
4 Late discharge, medically necessary
9 Other special charges

23X Incremental Nursing Charge Rate

Subcategories

0 General classification
1 Nursery
2 OB
3 ICU
4 CCU
9 Other

24X All Inclusive Ancillary
A flat rate charge incurred on either a daily or total stay basis for ancillary services only.

Subcategories

0 General classification
9 Other inclusive ancillary

25X Pharmacy
Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under direction of licensed pharmacies.

Subcategories

0 General classification
1 Generic drugs
2 Nongeneric drugs
3 Take home drugs
4 Drugs incident to other diagnostic services
5 Drugs incident to radiology
6 Experimental drugs
7 Nonprescription
8 IV solutions
9 Other pharmacy

26X IV Therapy
Equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategories

0 General classification
1 Infusion pump
2 IV therapy/pharmacy services
3 IV therapy/drug/supply delivery
4 IV therapy/supplies
9 Other IV therapy

27X Medical/Surgical Supplies and Devices (also see 62X, an extension of 27X)
Charges for supply items required for patient care.

Subcategories

0 General classification
1 Nonsterile supply
2 Sterile supply
3 Take home supplies
4 Prosthetic/orthotic devices
5 Pacemaker
6 Intraocular lens
7 Oxygen – take home
8 Other implants
9 Other supplies/devices

28X Oncology
Charges for the treatment of tumors and related diseases.

Subcategories

0 General classification
9 Other oncology

29X Durable Medical Equipment (other than renal)
Charges for medical equipment that can withstand repeated use (excluding renal equipment).

Subcategories

0 General classification
1 Rental
2 Purchase of new DME
3 Purchase of used DME
4 Supplies/drugs for DME effectiveness (home health agency only)
9 Other equipment

30X Laboratory
Charges for the performance of diagnostic and routine clinical laboratory tests. For outpatient services, be sure to indicate the code for each lab charge in UB-92 form field number 44.

Subcategories

0 General classification
1 Chemistry
2 Immunology
3 Renal patient (home)
4 Nonroutine dialysis
5 Hematology
6 Bacteriology and microbiology
9 Other laboratory

31X Laboratory – Pathological
Charges for diagnostic and routine laboratory tests on tissues and cultures.

For outpatient services, indicate the CPT code for each lab charge in UB-92 form field number 44.

Subcategories

0 General classification
1 Cytology
2 Histology
4 Biopsy
9 Other

32X Radiology – Diagnostic
Charges for diagnostic radiology services provided for the examination and care of patients. Includes taking, processing, examining and interpreting of radiographs and fluorographs.

Subcategories

0 General classification
1 Angiocardiography
2 Arthrography
3 Arteriography
4 Chest x-ray
9 Other

33X Radiology – Therapeutic

Charges for therapeutic radiology services and chemotherapy required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Subcategories

0 General classification
1 Chemotherapy – injected
2 Chemotherapy – oral
3 Radiation therapy
5 Chemotherapy – IV
9 Other

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Subcategories

0 General classification
1 Diagnostic
2 Therapeutic
9 Other

35X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Subcategories

0 General classification
1 Head scan
2 Body scan
9 Other CT scans

36X Operating Room Services
Charges for services provided to patients by those specifically trained nursing personnel providing assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Subcategories

0 General classification
1 Minor surgery
2 Organ transplant – other than kidney
7 Kidney transplant
9 Other operating room services

37X Anesthesia
Charges for anesthesia services in the hospital.

Subcategories

0 General classification
1 Anesthesia incident to radiology
2 Anesthesia incident to other diagnostic services
4 Acupuncture
9 Other anesthesia

38X Blood
Charges for blood must be separately identified for private payer purposes.

Subcategories

0 General classification
1 Packed red cells
2 Whole blood
3 Plasma
4 Platelets
5 Leukocytes
6 Other components
7 Other derivatives (cryoprecipitates)
9 Other blood

39X Blood Storage and Processing
Charges for the storage and processing of whole blood.

Subcategories

0 General classification
1 Blood administration
9 Other blood storage and processing

40X Other Imaging Services

Subcategories

0 General classification
1 Diagnostic mammography
2 Ultrasound
3 Screening mammography
4 Positron emission tomography
9 Other imaging services

41X Respiratory Services
Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure. Charges for other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Subcategories

0 General classification
1 Inhalation services
3 Hyperbaric oxygen therapy
9 Other respiratory services

42X Physical Therapy
Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
3 Group rate
4 Evaluation or reevaluation
9 Other occupational therapy/trial occupational therapy – rehab agency

43X Occupational Therapy
Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
3 Group rate
4 Evaluation or reevaluation
9 Other occupational therapy/trial occupational therapy – rehab agency

44X Speech – Language Pathology
Charges for services provided to those with impaired functional communication skills.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
3 Group rate
4 Evaluation or reevaluation
9 Other speech-language pathology/trial speech therapy – rehab agency

45X Emergency Room
Charges for emergency treatment to those ill and injured persons requiring immediate unscheduled medical or surgical care.

Subcategories

0 General classification
9 Other emergency room

46X Pulmonary Function
Charges for tests measuring inhaled and exhaled gases. Charges for the analysis of blood and for tests evaluating the patient's ability to exchange oxygen and other gases.

Subcategories

0 General classification
9 Other pulmonary function

47X Audiology
Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Subcategories

0 General classification
1 Diagnosis
2 Treatment
9 Other audiology

48X Cardiology
Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress tests.

Subcategories

0 General classification
1 Cardiac cath lab
2 Stress test
9 Other cardiology

49X Ambulatory Surgical Care
Charges for ambulatory surgery not covered by other categories.

Subcategories

0 General classification
9 Other ambulatory surgical care

50X Outpatient Services
Outpatient charges for services rendered to an outpatient admitted as an inpatient before midnight of the day following the date of service.

Subcategories

0 General classification
9 Other outpatient services

51X Clinic
Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Subcategories

0 General classification
1 Chronic pain center
2 Dental clinic
3 Psychiatric clinic
4 OB-GYN clinic
5 Pediatric clinic
9 Other clinic

52X Free-Standing Clinic

Subcategories

0 General classification
1 Rural health – clinic
2 Rural health – home
3 Family practice
9 Other free-standing clinic

53X Osteopathic Services
Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Subcategories

0 General classification
1 Osteopathic therapy
9 Other osteopathic services

54X Ambulance
Charges for ambulance service, usually on an unscheduled basis to the ill and injured requiring immediate medical attention.

Note: Ambulance is payable on the UB-92 form **only** in conjunction with inpatient admissions. Other ambulance charges must be submitted on the ambulance claim form. Documentation of medical necessity must be provided for ambulance transport. The diagnosis/documentation must reflect that the patient was nonambulatory and the trip was to the nearest adequate facility.

Subcategories

0 General classification
1 Supplies
2 Medical transport
3 Heart mobile
4 Oxygen
5 Air ambulance
6 Neonatal ambulance services
7 Pharmacy
8 Telephone transmission EKG
9 Other ambulance

55X Skilled Nursing (home health agency only)
Charges for nursing services that must be provided under the direct supervision of a licensed nurse ensuring the safety of the patient and achieving the medically desired result.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
9 Other skilled nursing

56X Medical Social Services (home health agency only)
Charges for services such as counseling patients, interviewing and interpreting problems of social situations provided to patients on any basis.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
9 Other medical social services

57X Home Health Aide (home health agency only)
Charges made by a home health agency for personnel primarily responsible for the personal care of the patient.

Subcategories

0 General classification
1 Visit charge
2 Hourly charge
9 Other home health aide services

61X MRI
Charges for Magnetic Resonance Imaging of the brain and other body parts.

Subcategories

0 General classification
1 Brain (including brainstem)
2 Spinal cord (including spine)
9 Other MRI

62X Medical/Surgical Supplies (extension of 27X)
Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode 2 is for providers that cannot bill supplies used for other diagnostic procedures.

Subcategories

1 Supplies incident to radiology
2 Supplies incident to other diagnostic services

63X Drugs Requiring Specific Identification
Charges for drugs and biologicals requiring specific identification as required by the payer. If HCPCS is used to describe the drug, enter the HCPCS code in UB-92 form field number 44.

Subcategories

0 General classification
1 Single source drug
2 Multiple source drug
3 Restrictive prescription
4 Erythropoietin (EPO), less than 10,000 units
5 Erythropoietin (EPO), 10,000 or more units
6 Drugs requiring detailed coding

64X Home IV Therapy Services
Charges for intravenous drug therapy services performed in the patient's residence. For home IV providers the HCPCS code must be entered for all equipment and all types of covered therapy.

Subcategories

0 General classification
1 Nonroutine nursing, central line
2 IV site care, central line
3 IV site/change, peripheral line
4 Nonroutine nursing, peripheral line
5 Training patient/caregiver, central line
6 Training, disabled patient, central line
7 Training, patient/caregiver, peripheral line
8 Training, disabled patient, peripheral line
9 Other IV therapy services

65X Hospice Services (hospice only)
Charges for hospice care services for a terminally ill patient if he or she elects these services in lieu of other services for the terminal condition.

Subcategories

1 Routine home care
2 Continuous home care (hourly)
5 Inpatient respite care
6 General inpatient care
8 Care in an ICF or SNF

70X Cast Room
Charges for services related to the application, maintenance, and removal of casts.

Subcategories

0 General classification
9 Other cast room

71X Recovery Room

Subcategories

0 General classification
9 Other recovery room

72X Labor Room/Delivery
Charges for labor and delivery room services provided by specially trained nursing personnel to patients. This includes prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if performed in the delivery suite.

Subcategories

0 General classification
1 Labor
2 Delivery
3 Circumcision
4 Birthing center
9 Other labor room/delivery

73X EKG/ECG (electro-cardiogram)
Charges for the operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiography for the diagnosis of heart ailments.

Subcategories

0 General classification
1 Holter monitor
2 Telemetry
9 Other EKG/ECG

74X EEG (electro-encephalogram)
Charges for the operation of specialized equipment measuring impulse frequencies and differences in electrical potential in various brain areas to obtain data used in diagnosing brain disorders.

Subcategories

0 General classification
9 Other EEG

75X Gastro-Intestinal Services
Procedure room charges for endoscopic procedures not performed in the operating room.

Subcategories

0 General classification
9 Other gastro-intestinal

76X Treatment or Observation Room
Charges for the use of a treatment room or for the room charge associated with outpatient observation services. HCPCS code W9220 must be used with these codes (one unit per hour) on outpatient claims.

Subcategories

0 General classification
1 Treatment room
2 Observation room
9 Other treatment/observation room

79X Lithotripsy
Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategories

0 General classification
9 Other lithotripsy

80X Inpatient Renal Dialysis
A waste removal process performed in an inpatient setting using an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Subcategories

0 General classification
1 Inpatient hemodialysis
2 Inpatient peritoneal (nonCAPD)
3 Inpatient continuous ambulatory peritoneal dialysis
4 Inpatient continuous cycling peritoneal dialysis (CCPD)
9 Other inpatient dialysis

81X Organ Acquisition (see 89X)
The acquisition of a kidney, liver or heart for transplant use. (All other human organs fall under category 89X.)

Subcategories

0 General classification
1 Living donor – kidney
2 Cadaver donor – kidney
3 Unknown donor – kidney
4 Other kidney acquisition
5 Cadaver donor – heart
6 Other heart acquisition
7 Donor – liver
9 Other organ acquisition

82X Hemodialysis – Outpatient or Home
A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Subcategories

0 General classification
1 Hemodialysis/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient hemodialysis

83X Peritoneal Dialysis – Outpatient or Home
A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategories

0 General classification
1 Peritoneal/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient peritoneal dialysis

84X Continuous Ambulatory Peritoneal Dialysis (CCPD) – Outpatient or Home
A continuous dialysis process performed in an outpatient or home setting using the patient peritoneal membrane as a dialyzer.

Subcategories

0 General classification
1 CAPD/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient CAPD

85X Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home
A continuous dialysis process performed in an outpatient or home setting using a machine to make automatic changes at night.

Subcategories

0 General classification
1 CCPD/composite or other rate
2 Home supplies
3 Home equipment
4 Maintenance/100%
5 Support services
9 Other outpatient CCPD

88X Miscellaneous Dialysis
Charges for dialysis services not identified elsewhere.

Subcategories

0 General classification
1 Ultrafiltration
2 Home dialysis aid visit
9 Miscellaneous dialysis other

89X Other Donor Bank (extension of 81X)
Charges for the acquisition, storage, and preservation of all human organs (excluding kidneys, livers, and hearts – see 81X).

Subcategories

0 General classification
1 Bone
2 Organ (other than kidney)
3 Skin
9 Other donor bank

92X Other Diagnostic Services

Subcategories

0 General classification
1 Peripheral vascular lab
2 Electromyelogram
3 Pap smear
4 Allergy test
5 Pregnancy test
9 Other diagnostic services

94X Other Therapeutic Services

Charges for other therapeutic services not otherwise categorized.

Subcategories

0 General classification
1 Recreational therapy
2 Education/training
3 Cardiac rehabilitation
4 Drug rehabilitation
5 Alcohol rehabilitation
6 Complex medical equipment – routine
7 Complex medical equipment – ancillary
9 Other therapeutic services

99X Patient Convenience Items

Charges for items generally considered by the third party payers to be strictly convenience items, and, therefore, are not covered.

Subcategories

0 General classification
1 Cafeteria/guest tray
2 Private linen service
3 Telephone/telegraph
4 TV/radio
5 Nonpatient room rentals
6 Late discharge charge
7 Admission kits
8 Beauty shop/barber
9 Other patient convenience items

43.	REVENUE DESCRIPTION	**OPTIONAL** – Enter a description of each revenue code billed.
44.	HCPCS/CPT/ RATES	**CONDITIONAL*** – Outpatient Hospital – Enter the HCPCS/CPT code for each service billed, assigning a procedure, ancillary or medical APG. Inpatient SNF – Enter the HCPCS code W0511 for ventilator dependent patients, otherwise leave blank. Home Health Agencies – Enter the appropriate HCPCS code from the prior authorization when billing for EPSDT related services. All Others – Leave blank.
45.	SERVICE DATE	**OPTIONAL** – Entry in this field is optional for outpatient and no entry required for all others.
46.	UNITS OF SERVICE	**REQUIRED** – Inpatient – Enter the appropriate units of service for accommodation days. Outpatient – Enter the appropriate units of service provided per CPT/revenue code. (Batch-bill APGs require one unit = 15 minutes of service time.) Home Health Agencies – Enter the appropriate units for each service billed. A unit of service = a visit. Prior authorization private duty nursing/personal care – one unit = an hour.
47.	TOTAL CHARGES	**REQUIRED** – Enter the total charges for each code billed.
48.	NONCOVERED CHARGES	**REQUIRED** – Enter the noncovered charges for each applicable code.
49.	UNLABELED FIELD	**OPTIONAL** – No entry required.

50. A. – C.	PAYER IDENTIFICATION	**REQUIRED** – Enter the designation provided by the state Medicaid agency. Enter the name of each payer organization from which you might expect some payment for the bill.
51.	PROVIDER NUMBER	**REQUIRED** – Enter your seven-digit Medicaid provider number.
52. A. – C.	RELEASE OF INFORMATION CERTIFICATION INDICATOR	**OPTIONAL** – No entry required.
53. A. – C.	ASSIGNMENT OF BENEFITS…	**OPTIONAL** – No entry required.
54. A. – C.	PRIOR PAYMENTS	**REQUIRED** – If applicable, enter the amount paid by third-party payer. Do not enter previous Medicaid payments.
55. A. – C.	ESTIMATED AMOUNT DUE	**OPTIONAL** – No entry required.
56. – 57.	UNLABELED FIELDS	**OPTIONAL** – No entry required.
58. A. – C.	INSURED'S NAME	**REQUIRED** – Enter the Medicaid recipient's last name, first name, and middle initial. Verify this information on the *Medical Assistance Eligibility Card*.
59. A. – C.	PATIENT'S RELATIONSHIP TO INSURED	**OPTIONAL** – No entry required.
60. A. – C.	CERTIFICATE/ SOCIAL SECURITY NUMBER/HEALTH INSURANCE CLAIM/IDENTI-FICATION	**REQUIRED*** – Enter the patient's Medicaid identification number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.

61. A. – C.	INSURED GROUP NAME	**OPTIONAL*** – No entry required.
62.	INSURANCE GROUP NUMBER	**OPTIONAL*** – No entry required.
63.	TREATMENT AUTHORIZATION CODE	**CONDITIONAL** – If the patient is a MediPASS patient and the service is not an emergency, the physician authorization number must be shown here.
64. – 66.	EMPLOYMENT STATUS, EMPLOYER NAME AND LOCATION	**OPTIONAL*** – No entry required.
67.	PRINCIPAL DIAGNOSIS CODE	**REQUIRED** – Enter the ICD-9-CM code for the principal diagnosis.
68. – 75.	OTHER DIAGNOSIS CODES	**CONDITIONAL** – Enter the ICD-9-CM codes for diagnosis, other than principal, for the additional diagnosis.
76.	ADMITTING DIAGNOSIS	**OPTIONAL** – No entry required.
77.	"E" CODE	**OPTIONAL** – No entry required.
78.	DRG ASSIGNMENT	**OPTIONAL** – No entry required.
79.	PROCEDURE CODING METHOD USED	**OPTIONAL** – No entry required.
80.	PRINCIPAL PROCEDURE AND DATE	**CONDITIONAL** – For the principal surgical procedure, enter the ICD-9-CM procedure code and surgery date, when applicable.
81.	OTHER PROCEDURE CODES AND DATES	**CONDITIONAL** – For additional surgical procedures, enter the ICD-9-CM procedure codes and dates.

82.	ATTENDING PHYSICIAN ID	**REQUIRED** – Inpatient Hospital, SNF, Rehab Agency, Home Health Agency, and PMIC – Enter the UPIN or seven-digit Iowa Medicaid provider number for the treating physician. The last name, first initial, and discipline are also needed. The treating physician has primary responsibility for the patient's care from the start of hospitalization. Outpatient – Enter the UPIN or seven-digit Iowa Medicaid provider number of the physician referring the patient to the hospital. This area should not be completed if the primary physician did not give the referral. On outpatient billings, do not show treating physician information in this area. **Note:** For lock-in patients, enter the seven-digit Iowa Medicaid provider number of the lock-in physician or clinic in place of the above.
83.	OTHER PHYSICIAN ID	**OPTIONAL** – Enter the UPIN number of physician performing the principal procedure, if applicable. If a UPIN number is unavailable, enter the physician's seven-digit Iowa Medicaid provider number. The last name, first initial, and discipline are also needed.
84.	REMARKS	**OPTIONAL** – No entry required.
85.	PROVIDER REPRESENTATIVE SIGNATURE	**REQUIRED** – The signature of an authorized representative must be shown. If the signature consists of computer-generated block letters, the signature must be initialed. A signature stamp may be used.
86.	DATE BILL SUBMITTED	**REQUIRED** – Enter the original claim submission date. For resubmissions, be sure to indicate the original submission date, not the date of resubmission.
BACK OF FORM	**NOTE**	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

Reserve page 43 for Claim Form, UB-92, HCFA-1450.

Reserve page 44 for Claim Form, UB-92, HCFA-1450.

B. Facsimile of Claim Form, UB-92 (front and back)

(See the preceding pages.)

IV. REMITTANCE ADVICE AND EXPLANATION

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Inpatient Remittance Advice

(See the following pages.)

Reserve page 47 for Remittance Advice.

Page 48 was intentionally left blank.

C. Inpatient Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Coverage dates as they appear on the claim.

12. DRG code.

13. Total number of covered days.

14. Total charges submitted by provider.

15. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

16. Total amount of Medicaid reimbursement as allowed for this claim.

17. Total noncovered charges as they appear on claim.

18. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for EOB code explanations.

19. Medical record number as assigned by provider; 10 characters are printable.

20. Difference between submitted charge and reimbursement amount.

21. Adjusted claims and reason codes. Codes are explained at the end of the *Remittance Advice.*

22. Difference in submitted charge and reimbursement amount resulting in a credit to Medicaid.

23. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and amount billed by provider.
    - Number of denied adjusted claims and amount billed by provider.
    - Number of pended claims (in process) and amount billed by provider.
    - Amount of check.

24. Description of individual adjustment reason codes.

25. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-81
Employees' Manual, Title 8
Medicaid Appendix

September 7, 1998

HOSPICE SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Hospice Services Manual***, Table of Contents (pages 4 and 5), revised; Chapter F, *Billing and Payment*, pages 1 through 29, revised; and pages 30 through 50, new.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***Hospice Services Manual*** and destroy them:

Page	Date
Contents (pages 4 and 5)	April 1, 1991
Chapter F	
1	January 1, 1990
2	1/90
3, 4	July 1, 1991
5, 6	January 1, 1990
7	1/90
8, 9	January 1, 1990
10	Undated
11-23	January 1, 1990
24	Undated
25-27	05/30/84
28, 29	January 1, 1990

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-101
Employees' Manual, Title 8
Medicaid Appendix

February 5, 1999

HOSPICE SERVICES MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Hospice Services Manual***, Table of Contents (page 4), revised; Chapter E, *Coverage and Limitations*, pages 1 through 3, 4, 5 through 9, 14 through 16, revised; and Chapter F, *Billing and Payment*, page 16, revised.

Chapters E and F are revised to reflect changes as a result of the Balanced Budget Act of 1997. These revisions:

- Update the definition of terminal illness.
- Move physician services from core services to supplemental services.
- Add the Medicare waiver provision for therapy providers.
- Remove the section regarding Medicare coinsurance.
- Update the billing form to the UB-92 (HCFA-1450).
- Define the new election period for hospice benefits.
- Add the requirement for claims to identify the geographic location at which the service is provided for routine and continuous home care.

Date Effective

December 1, 1998

Material Superseded

Remove the following pages from the ***Hospice Services Manual*** and destroy them:

Page	Date
Contents (page 4)	September 1, 1998
Chapter E	
1, 2	January 1, 1990
3, 4, 4a	April 1, 1991
5-9	January 1, 1990
14	April 1, 1991
15	January 1, 1990
16	April 1, 1991
Chapter F	
16	September 1, 1998

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.